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Child Abuse and Its Implications for Physical Therapists

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University of North Dakota

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CHILD ABUSE AND ITS IMPLICATIONS FOR PHYSICAL THERAPISTS

by

Tanya Surdez
Bachelor of Science in Physical Therapy
University of North Dakota, 1997

An Independent Study

Submitted to the Graduate Faculty of the

Department of Physical Therapy

School of Medicine

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Physical Therapy

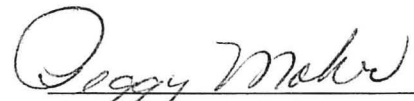
Grand Forks, North Dakota

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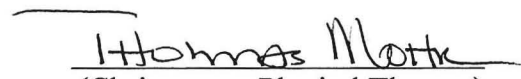
1997



This Independent Study, submitted by Tanya Surdez in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Faculty Preceptor, Advisor, and Chairperson of Physical Therapy under whom the work has been done and is hereby approved.


(Faculty Preceptor)


(Graduate School Advisor)


(Chairperson, Physical Therapy)

PERMISSION

Title Child Abuse and Its Implications for Physical Therapists

Department Physical Therapy

Degree Masters of Physical Therapy

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To the children in my life: Thank you for your inspiration. You are earth angels who have given me an eternal song in my heart. God bless you!

Above all, I want to thank God for giving me life and for all of the blessings I have been given. With God watching over me and Jesus Christ within my heart, I need not be afraid. I have all that I need.

ABSTRACT

Child abuse has existed for many centuries, but has only recently been recognized as a serious social problem. Child abuse affects millions of children each year from all income, racial and ethnic groups; thereby affecting society as a whole. Many studies have shown the devastating psychological, social, cognitive and physical effects of child abuse. There are a limited number of studies that demonstrate the role of physical therapists in working with victims of abuse. It is necessary that therapists learn to recognize signs and symptoms of abuse and know the appropriate action to take.

The purpose of this study is to review the literature; thereby giving an overview of child abuse, its history, its effects, predisposing risk factors and a therapist's role in recognizing and treating the abused child. The proposed results of this study are to increase awareness about child abuse as a significant social problem and to give therapists an idea of how to recognize warning signs and take appropriate actions in treating victims of abuse.

CHAPTER I

INTRODUCTION

Child abuse has only recently been recognized as a significant social problem, but it has been occurring longer than one might think.¹ There is archeological evidence of child abuse and neglect since prehistoric times. For hundreds of years, cultural norms have considered severe physical punishment necessary to maintain discipline; transmit educational, cultural, moral and religious ideas; please gods; and expel evil spirits.

Children were considered “little adults” and were not protected any differently than adults under the law in recent history.¹ In fact, an association for animal protection was in place before any such association for children. Eventually, however, children became recognized as a special class of people and legislation was enacted to protect their best interests. In 1909, the first White House Conference on Children was held. Soon after, in 1912, legislation was passed to create the Federal Children’s Bureau to deal with child welfare issues. Finally, in 1974, Congress passed the Child Abuse Prevention and Treatment Act.² This act defined child abuse as “the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child’s welfare under circumstances which indicate the child’s health or welfare is harmed or threatened thereby.”^{2(pp.25)} It was later revised to include an “endangerment standard” in which cases are counted if a child’s health or safety is endangered through abusive or neglectful treatment.¹

An estimated 1 to 6 million children are abused and neglected each year in the United States.¹ In 1993, Child Protective Services received 2,989,000 reports of alleged victims of abuse.³ Reports of child maltreatment have increased by 6% each year in the past 10 to 15 years. Of the substantiated cases of child maltreatment, approximately 46% are cases of neglect, 22% physical abuse, 13% sexual abuse, and 19% are for other forms of child maltreatment.⁴ Most cases are said to go unreported,⁵ especially sexual abuse.⁶ It is estimated that 1 of every 3 females and 1 of every 6 males is sexually abused before age 18.³ Fifty-eight percent of these children repress and never retrieve memories of the abuse, but are still affected by the abuse in virtually every aspect of their lives.³ Child abuse is found in all income, racial, and ethnic groups,⁴ thereby affecting society as a whole. With an incidence rate like that given above, child maltreatment has earned concern and categorization as a devastating social problem¹ and must be arrested. The purpose of this independent study is to review the literature, thereby, giving an overview of the incidence of child abuse and neglect, a brief review of its effect on development, predisposing/risk factors, and therapists' roles in recognizing signs and symptoms of abuse and in treating the abused child.

CHAPTER II

PREDISPOSING/RISK FACTORS

There are many theories concerning the etiology of abuse; however, none of them offer simple explanations. The occurrence of abuse is influenced by individual, family, and societal factors.¹

Certain individual character traits have been consistently found in abusing parents. Although there is no set recipe to making an abusive parent, the factors shown in table 2.1^{2,7-10} on the following page are some of those found to recur in a majority of abusers.

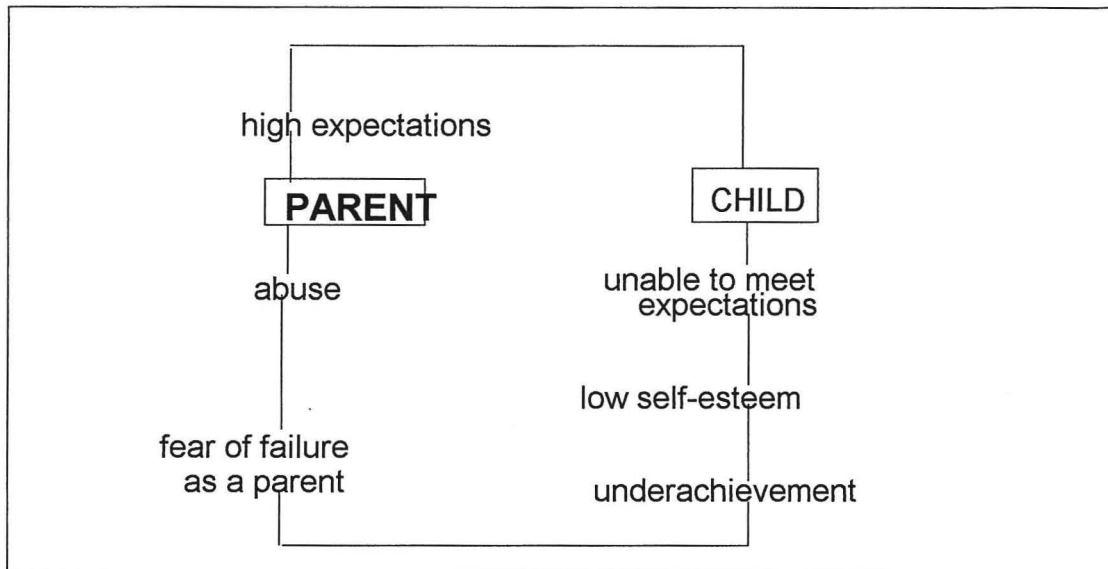
In most cases, abusive parents are not emotionally mature and they have unhealthy coping mechanisms.⁷ Many abusive parents haven't learned the appropriate ways to have their needs met⁷ and they turn to unhealthy/abusive means. Often they need to be needed and, when their children seek independence, these parents are not able to tolerate the separation process and become resentful.² Most abusive parents haven't learned the difference between feelings and actions.⁷ Feelings become actions as anger is demonstrated through abuse rather than recognized as a feeling and dealt with in a nondestructive way. Many abusive parents haven't learned to make decisions and they haven't learned that they are responsible for their own actions. They haven't learned to delay gratification and an instant need for control results in abuse. Abusive parents often set very high expectations for their children due to a lack of knowledge of development.

Table 2.1* CHARACTERISTICS OF ABUSIVE PARENTS

social isolation	secretiveness
emotional neediness	over-protectiveness
drug or alcohol abuse	marital or other stress
unrealistically high expectations of children	unrealistic goals
financial stress	desire for escape
desire for immediate gratification	depression
desire for control	unsupportive partner
inability to cope with stress	young age
role reversal with children	little education
abused as children	bond poorly to children
low self-esteem	lack knowledge of growth and development
insecurity	negative perception of life events
loss of control of life	authoritarian-type discipline

*Table compiled from various resources.^{2,7-10}

When children fail to meet these expectations they feel that they have failed their parents. The parents fear their own failure, which leads to abuse and more unrealistic expectations, thus continuing the cycle of abuse (shown in the diagram on the following page).⁷



Certain characteristics of the child seem to be motivators for abusive parents.⁶ A child who is the wrong sex (sex opposite that desired by the parent) is more likely to be abused. Often children that resemble a hated relative or former spouse are abused. When the abuser transfers his/her aggression onto the child rather than the hated individual, it is called transference. Children that are hyperactive are more likely to be abused because of the parents' feeling of being out of control of the child and wanting control. Children that are unable to play the role of the adult/parent as expected of them are the targets of abuse. Finally, children with disabilities or chronic illnesses are often the victims of abuse. This is most likely due to the child's inability to live up to expectations, the stress that comes with caring for a child with special needs, resentment and grief felt for the loss of a "normal" child, and the sense of hopelessness and lack of control felt by some parents of children with disabilities. Unfortunately, these children are often at an even greater disadvantage

because they are less likely to report abuse (and be believed) due to communication barriers caused by their disability.

Along with individual characteristics of child and parent, society and other external factors play a role in abuse.⁹ The family's socioeconomic status, living conditions, employment status, and surrounding support system (or lack thereof) contribute to the stresses perceived by the parents; combined with the lack of coping strategies and the perception that children are the cause of financial hardship, these external stressors often motivate abuse. Some cultures tolerate and support violence as a means of maintaining control in the home.¹ They may offer few consequences and little punishment for domestic violence. This tolerance of violence contributes to ongoing abuse with the rationale that it is a socially accepted means of parenting.

Tzeng et al¹ have condensed the many theories on etiology of abuse into three bipolar paradigms that link all of the previously mentioned factors. The first of the three theories is called the "individual-environment interaction paradigm" and links the following variables in the etiology of abuse:

- 1) the perpetrator's personality traits
- 2) the perpetrator's personal resources such as self-esteem, parenting skills, and coping mechanisms
- 3) personal stressors
- 4) cognitive processes
- 5) family characteristics
- 6) community values/norms concerning the acceptance of violence, child rearing practices, and community isolation

- 7) sociocultural variables such as socioeconomic status and social controls of behavior
- 8) characteristics of the child such as prematurity, hyperactivity, and low birth weight.

The individual-environment theory proposes that individual weaknesses or characteristics such as authoritarianism, emotional neediness, psychological problems, low self-esteem, poor coping mechanisms, and a negative attitude toward a child predispose an individual to the potential for being abusive.¹ These risk factors within an individual interact with external factors such as societal acceptance of violence, low socioeconomic status, community isolation, and hyperactivity of the child to further increase the chance of abuse. The external stressors test the individual's ability to cope and tax the parent's resources. Since most abusive parents have been shown to lack effective coping strategies, the parents are predisposed to turn to abusive behaviors.

The second theory, the "family systems paradigm", takes into account individual characteristics; family characteristics such as structure, values, dynamics and interaction with other systems; and sociocultural variables such as social stress, community structure, level of societal violence, community tolerance of violence, and the social consequences of violence.¹ This theory "considers child abuse as the product of the entire family unit. The family unit is influenced by individual members and surrounding social systems."¹

Characteristics of the family that put a family at risk such as large size, acceptance of violence, dysfunctional interactions among members, and lack of positive feedback are further aggravated by a lack of support structures within the community, social tolerance of abuse, lack of social consequences of abuse, and a violent community environment.

Finally, the “ecological determinants paradigm” states that abuse is influenced by four ecological levels: individual, family, community, and society.¹ Community variables include the number and quality of support systems available, stressors within the community, and the degree of social isolation. Societal influences include the attitudes, beliefs, and tolerance of abuse within that society. According to this theory, individuals are thought to be “a product of family, community, and cultural influences.”¹ Past experiences form an individual with faulty/unhealthy perceptual processes who enters a family system with poor parenting skills. Stressors within the family, such as dysfunctional interactions among members and increased family size, test a parent’s ability to cope. Without support available within the community, that parent may not find healthy ways to cope with stress. Combined with a society that supports violence as a form of discipline, the above factors act together to result in abuse.

As is shown by the multi-level theories of etiology, there is no single cause of abuse.¹ Its occurrence is influenced by many individual, familial and societal factors. All of these factors interact to varying degrees to determine the fate of potential victims of abuse.

CHAPTER III

EFFECTS OF CHILD ABUSE

The effects of child abuse are multiple and all-encompassing. Victims of child abuse suffer physical injury as well as cognitive, social and emotional delays in development.¹¹⁻¹⁸ Normal development is defined as “a series of interlocking cognitive, social and emotional competencies that is characterized by the integration of earlier competencies into adaptive modes of functioning at later developmental periods.” The integration of these competencies is disrupted in victims of abuse and they experience a pathological or delayed course of development. Diminished cognitive, social and emotional competency has been shown across age groups and in all types of abuse (physical, sexual, neglect).

Some of the most harmful effects are seen in victims of neglect.^{8,13-18} Neglect can take the form of psycho-social, emotional, and/or nutritional deprivation and can even take place before birth through the lack of prenatal care.¹³ Neglected children have been shown to perform poorly in school, especially reading and language skills.⁸ They are usually socially and emotionally withdrawn and have difficulty relating to peers. Social development is predicted by a child’s initial relationship with the primary caregiver. This relationship affects the child’s expectations of others, relationships, self-esteem and social skills. Since abused/neglected children usually form insecure attachments to primary

caregivers, they don't develop a normal sense of autonomy and empathy that is necessary in forming healthy peer relationships.

Another effect of neglect that has been the topic of various studies is a syndrome called failure-to-thrive (FTT).^{13,15} FTT is characterized by a failure to gain weight, decreased linear growth, and a delay in psychomotor development. There are two types of FTT. The first is organic FTT which, as the name implies, is delay in development resulting from organic causes. Specific to cases of neglect is non-organic FTT in which there is no organic cause for delay; rather, the child's social, emotional, or nutritional environment is disturbed enough to interfere with normal growth and development. Physical examination of children with FTT will usually show muscle wasting (most easily seen in gluteals and thighs), enlarged head, delay in all milestones, cold hands and feet, healing fractures (on X-ray), persistence of infantile posture, withdrawn and apathetic behavior, and, most notably, they will be underweight.

Non-organic FTT was first noted in 1915 by Henry Chaplin¹⁵ with emotional deprivation of children living in institutions. Although Chaplin's findings came as early as 1915, the first truly recognized study was not until 1945 and was conducted by Spitz.¹⁵ He found children in homes to suffer from depression, malnutrition and growth failure. The main reason for the depression and growth failure was thought to be the lack of emotional stimulation. In 1957, Coleman and Provence¹⁵ found that FTT could occur in children living in their own homes through inadequate care and nutrition.

A similar but distinct disorder is called deprivation dwarfism.¹⁵ These children are most notably short in stature. They don't appear to be malnourished, but they often hoard food and display binge feeding patterns. A decreased amount of pituitary hormone has

been found in some children with deprivation dwarfism. Following removal from their emotionally disturbed home environment, these children grew and the release of growth hormone returned to normal. The suggestion made by researchers¹⁵ studying deprivation dwarfism is that emotional deprivation may affect the hypothalamic-pituitary axis to inhibit growth hormone secretion (causing the resultant delay in growth).

A second form of child maltreatment, other than neglect, is child sexual abuse. Sexual abuse has been referred to as “soul murder.”³ Victims of child sexual abuse are affected in all dimensions: physically, sexually, emotionally, mentally, developmentally, and socially. Results of sexual abuse include feelings of anger, guilt, shame, fear, depression, an exaggerated startle reflex, an inability to trust, inability to form close relationships, helplessness, hopelessness, worthlessness, low self-esteem, isolation, fear of touch, eating and somatic disorders, and self-injury. Sexually abused children also display aggression and behavior problems resulting in poor relationships with peers and poor performance in school. The amount of damage to the victim is influenced by the following factors: 1) the age of the victim (the younger the victim, the more damage that’s done); 2) the frequency of abuse (a few incidents spread out over time is less damaging than frequent episodes); 3) duration (longer duration is more damaging); 4) relationship to the perpetrator (closer relationship causes increased distress); 5) child’s interpretation of the abuse (may feel shame or guilt).

The effects that most often lead to referral of victims of child abuse to medical and social services are the physical injuries caused by neglect or abuse.¹⁶ Physical injuries common in abuse include brain injury, burns, bruises and other skin lesions (most common sign of physical abuse), fractures, eye injuries (i.e. retinal hemorrhages seen with shaking a

baby), poisoning, epiphyseal separation, and internal damage (due to blows to the abdomen).¹³⁻¹⁸ Head injuries due to abuse such as shaking the baby can cause death or incur permanent brain damage that will result in mental retardation, delayed development, and/or other serious handicapping conditions. In a study by Diamond and Jaudes¹⁸ in 1983, 20% of children with cerebral palsy were victims of abuse. Twenty to fifty percent of abused children will have significant impairment of neurologic functions.¹⁷ The neurologic system is the most vulnerable to abuse and is critical in determining the consequences of abuse. Neurologic impairment results in learning disorders, delayed gross motor and language skills, and the inability to complete abstract tasks.

By far the most damaging effects of abuse (physical, sexual, neglect) are on a child's social, emotional and cognitive development.¹⁶ Abuse changes the way children see themselves and the world around them. The effects of abuse lead children to fail socially, emotionally and educationally. Like their parents, abused children have low self-esteem, poor social skills, a lack of coping skills, a decreased capacity for empathy, and behavior problems.⁸

Many of the characteristic delays demonstrated by abused children are actually adaptations to (and effects of) their home environment.¹³⁻¹⁸ When a child has little verbal stimulation or parental feedback, he/she will show delays in language development.¹⁷ The same applies to motor development. One needs practice and encouragement for language or motor development to flourish. Language or motor activity may actually be discouraged in an abusive, "be seen and not heard" home environment. In order to adapt to the home environment and survive, the child may inhibit language and gross motor activities. Learning, exploration, initiative, and autonomy are not valued in most abusive

homes; thus the lack of development of these skills may actually be a child's way of surviving at home. Likewise, behavioral problems at school may be what has been learned as "safe" behavior for the child at home. The suggestion made is that certain neurologic signs may not be related simply to brain damage, but rather that the nervous system of an abused child is adapting to his/her environment. An abusive environment may not only result in impaired thinking but may also be the basis for tremors, incoordination, impaired perception, delayed language abilities, abnormal muscle tone, hyperreflexia, impaired balance and equilibrium, etc. In some cases, developmental delays improve quickly when the emotional environment of the home improves or the child is moved to a healthier environment.¹⁶

There are some children who show no long-term effects of abuse.¹⁸ Somewhere in the process of development, these children have had a healthy, normal relationship with an adult. They have been given the experience/opportunity to form some secure relationships with people they can trust. This healthy environment allowed for verbal and motor stimulation as well as emotional support necessary for normal development. It will become apparent in the following chapter that providing a safe and supportive environment is one role that a therapist may be given the opportunity to play.¹⁷

CHAPTER IV

IMPLICATIONS FOR PHYSICAL THERAPISTS

Due to the injuries incurred by child abusers, many victims of child abuse will be seen in clinical settings such as hospitals or outpatient clinics.^{1,2,7,16,17,19} When that happens, a physical therapist, along with other health professionals, becomes instrumental in helping the abused child. Therapists can help by treating developmental delays and physical injuries, providing a safe environment, recognizing signs and symptoms, and following necessary reporting procedures.

When a child is brought into the clinic, it is an excellent opportunity to evaluate the child and his/her behavior.¹⁷ It is important to evaluate the developmental level of the child. As stated in the previous chapter, victims of child abuse often present with developmental delays due to physical injury as well as the lack of a stimulating environment. It is also important to observe the child's coping mechanisms including his reaction to stress, peers, adults, and play activities. Observing how the parents interact with the child will also lead to indications of possible abuse. Abusive parents are often distant from the child, do not interact lovingly, and seem unable to meet the child's basic needs.

In working with a child, especially one suspected of being abused, it is important to communicate with the child, explaining what is going on and allowing him/her to express his/her feelings.¹⁷ Because an abusive home environment is usually unsafe,

unpredictable, and inconsistent, it is necessary to make the clinical environment as consistent as possible. This includes having the same therapist work with the child each session if possible and providing a safe, encouraging and structured environment.

The most obvious responsibility of a physical therapist is to treat the physical injuries and developmental delays of the child.¹⁷ In the case of abuse, traditional treatment may not be effective alone due to the fact that the causes of delay are both environmental and physical. Effective treatment must consist of physical and environmental components.

As with traditional treatment, treatment must start at the child's current level of functioning to allow for some success.¹⁷ Treatment progresses from lower to higher levels of functioning beginning in a prone position followed by quadruped, kneeling, and standing activities (starting at the appropriate level for the child). Introducing sensory input to these children is also important. It is essential in neurophysiological development. In fact, Rice et al¹⁷ researched and supported the idea that children with consistent tactile-kinesthetic input by parents developed faster neurophysiologically and socially than controls that did not receive this form of daily contact from parents. The fact that children in abusive homes generally are deprived of nurturing forms of physical contact and neurologic stimulation may explain the frequency of developmental delay in these children.

While treating abused children, therapists must be prepared and aware of behaviors and reasons behind behaviors of abused children (i.e. being passive aggressive, fearful, oppositional, etc.), and should create a supportive environment.¹⁷ Fostering a positive self-concept is essential to a child's well-being. The therapist should communicate that:

- 1) he/she likes the child regardless of the child's performance,
- 2) he/she is interested in helping,

3) he/she won't desert the child if he doesn't "act right", and

4) he/she is willing to listen or talk about feelings or injuries.

Besides treating children, physical therapists may play an important role in intervention of child abuse.^{1,2,7,16,17,19} Before intervention may take place, therapists need to be able to recognize signs and symptoms of abuse.^{7,17,19} Some of these signs and symptoms were mentioned in the preceding chapter. They can be physical, developmental, and behavioral signs. It is necessary, as with all other subjective and objective information found in the evaluation, to explicitly document all objective findings concerning signs and symptoms of abuse. Signs and symptoms can be documented easily in the form of a checklist or injury diagram (or both).^{2,7} Examples of a checklist and injury document can be found in Appendix A and B. Some clinics may have standard forms or checklists to be filed in cases of suspected abuse, or it may be necessary to develop such forms.

After evaluating and interpreting signs and symptoms, if abuse is strongly suspected, physical therapists must report their suspicions to the appropriate authorities.^{7,16,17,19} State reporting laws were passed in 1963 and were enacted throughout the country within the following four years.¹⁶ These laws have evolved and are slightly different from state to state. Every state has adopted some form of mandatory reporting law. Mandated reporters are required to report cases of suspected abuse. Mandated reporters include all health professionals, teachers, daycare workers, police officers, or anyone who comes in contact with the child professionally. Some states include the general public as mandated reporters. Another group of reporters are referred to as permissive reporters. These are people who are authorized to violate confidentiality but are not legally obligated to report abuse. Some states require only people who have direct

contact with the child to report while others require anyone with knowledge about possible abuse to report. Most states do not have a statute of limitations limiting the amount of time after the crime has occurred that it can be reported. This is an area in which a therapist may use discretion depending on the severity of the abuse and whether the perpetrator is still in a position to harm the child. Most states do, however, have laws specifying the time frame in which reports of suspected abuse should be made. In North Dakota, oral reports are to be made immediately and written reports are to be made within 48 hours of the initial session in which abuse became a suspected issue. Sometimes delays may be appropriate to gain more information so that a more therapeutic outcome for the family will result. (Please refer to Appendix C for an example of a report form.)

Each facility may have its own requirements for the reporting procedure.¹⁶ Usually therapists are supposed to report to their supervisor and the supervisor contacts social services. Social workers or the case manager may also be the vehicle for reporting. Reporting may actually help the abuser as well as the child in the long run.

In most states, penalties, although usually mild, exist for not reporting suspected child abuse.¹⁶ Failure to report can also be grounds for referral to a licensing board and a therapist can be held liable for damages attributable to failure to report. The fear many therapists may have is that they may be sued for reporting suspected child abuse if no such abuse is found. Civil suits can be filed against a reporter; however, immunity from civil liability is granted to professionals who make reports in “good faith” concerning suspected abuse. This reduces the chance that the reporter will be found to be at fault, as long as they act in good faith and provide appropriate documentation. Excellent forms of documentation other than daily notes include photographs, X-rays, and videotapes.

Many facilities promote the idea that the parents of the child should be informed of the therapist's findings and suspicions before authorities are contacted.¹⁶ It may seem to be a risk to the client-therapist relationship; however, if the report were hidden and the parents found out about it later, they may be more offended by the lack of honesty. Therapists may fear that parents will be angry and refuse further treatment, but it may be avoided if an empathetic approach is taken when presenting the differential diagnosis, allowing parents to reply at any time as they wish. At times, deceit may be justified if injury is particularly serious or the parents seem disturbed or dangerous and may cause further injury to the child.

Intervention is not only necessary for the child.¹⁻¹⁹ Abusive parents may be helped if they are aware of resources that are available to them.² Clinics may find it beneficial to have a resource rack with pamphlets and brochures available to parents. Information could be provided about child abuse, counseling options, support groups, and hot lines. The National Child Abuse Hot line (1-800-422-4453) is a 24-hour, 7 days a week service. It is answered by professional counselors and trained volunteers who provide help in crisis situations. They are able to make referrals to any county agency in the United States. This, along with all other resources, can help in possibly deterring future abuse.

CONCLUSION

Child abuse has only recently been recognized as a significant social problem, but it has been occurring since prehistoric times.¹ Laws to protect children were not in effect until the 20th century. Most notable was The Child Abuse Prevention and Treatment Act passed in 1974, which defined child abuse and established a precedent for the protection of children.²

An estimated 1-6 million children are abused and neglected each year in the United States.¹ Most cases of abuse are said to go unreported.⁵ Child abuse occurs in all income, racial, and ethnic groups,⁴ thereby affecting society as a whole. With such a high incidence rate, child maltreatment has earned categorization as a devastating social problem¹ which must be arrested.

There are many theories that attempt to explain the causes of child abuse, but none of them are simple.¹ The occurrence of abuse is influenced by individual, family and societal factors. Although there is no set prescription for making an abusive parent, abusive parents usually display some common characteristics.^{2, 7-10} Most abusive parents are not emotionally mature and they have unhealthy coping mechanisms. They often have unrealistic expectations and lack knowledge about normal development.

Social and environmental factors often increase the likelihood that parents will abuse their children.⁹ The family's socioeconomic status, living conditions, and

surrounding support system (or lack thereof) contribute to increased stress. Combined with the lack of coping skills and resentment toward children for financial hardship, these environmental factors often motivate abuse.

Characteristics of the child may also motivate parents to abuse their children.⁶ An unruly child or a child with disabilities may tax a parent's emotions and sense of control. In an attempt to regain control or react to undesirable behavior, a parent may lash out in an abusive manner.

Regardless of the cause of abuse, victims of child abuse suffer devastating effects.¹¹⁻¹⁸ The effects of child abuse and neglect are all-encompassing. Victims suffer physical injury as well as cognitive, social and emotional delays in development. Development is predicted by a child's relationship with the primary caregiver. Since abused/neglected children usually form insecure attachments to primary caregivers and receive little stimulation for development, they are set up to fail socially, emotionally and educationally.

The only chance for a child to emerge from an abusive childhood with no long-term effects may be for that child to have an opportunity to develop a normal, healthy and secure relationship with an adult.¹⁸ Providing a safe and supportive environment and facilitating trust is one role that a physical therapist may be given the opportunity to play.¹⁷

A therapist's role in treating victims of child abuse includes treating developmental delays and physical effects of abuse, providing a safe and consistent environment, recognizing signs and symptoms of abuse, and reporting suspicion of abuse to the appropriate authorities.^{1, 2, 7, 16, 17} A therapist must document all information pertaining to

the child and possible indications of abuse. Physical therapists are mandated reporters. They are required to report any suspicion of abuse. In the long run, recognizing and reporting abuse may lead to necessary help for both the child and the parent.

Physical therapists can play a key role in dulling the effects of child abuse. By recognizing signs and symptoms, treating delays, providing a safe and consistent environment, and reporting suspicions of abuse, therapists may be able to provide an avenue of safety for abused children. We may, in some cases, be providing a child with the only chance at living a safe and healthy life.

APPENDIX

Appendix A

Signs and Symptoms Checklist^{2,7,19}

PHYSICAL SIGNS	BEHAVIORAL SIGNS
different aged bruises or cuts	(parental behaviors) conflicting stories concerning cause of injuries
bruises or cuts on different planes of the body	delay in seeking medical attention
bruises inflicted by objects such as belts or cords	history of "hospital shopping"
dislocations or fractures (especially spiral fractures)	refusal of parent to allow child to receive treatment
burns in clearly defined areas indicating that the child was held down or hot objects were held on child (ie..cigarettes, stove...)	child is given inappropriate food, drink, or drugs
multiple unexplained injuries	neglect of physical needs of child
injuries not age appropriate	(child behaviors) regression from age appropriate behavior
injuries to the genital region	withdrawl or aggression
"sock and glove" type burns	developmental delays
repeated serious injuries	seek constant affection
appears undernourished	role-reversal
has a handicapping condition	fearful of adult contact
wetting and soiling	learning problems
unexplained abdominal swelling	blunted affect
bald spots (hair pulling)	hyperactivity
	poor self-esteem or fear of failure
	lack of familial attachment or fear of going home
	lack of empathy
	inability to establish appropriate relationships with peers
	self-destructive behavior

Appendix B
Injury Diagram²

Child's name:

Date:

Description of injuries
(may diagram injuries in space provided below)

Anterior

Posterior

Head:

Head:

Neck:

Neck:

Right UE:

Left UE:

Trunk:

Trunk:

Right LE:

Left LE:

Genitalia:

Genitalia:

Comments:

Appendix C

Sample Report Form^{2,7,19}

Date of Report: ____/____/____

Child's name: _____

Age: _____

Date of Birth: ____/____/____

Gender: ____ Male ____ Female

Address: _____

Father's name: _____

Father's Address: _____

Phone #: _____

Mother's name: _____

Mother's Address: _____

Phone #: _____

Reporter's name and title: _____

Reporter's Address: _____

Phone #: _____

Signs and Symptoms: _____

Circumstances under which injuries were noted: _____

Have caretakers been made aware of report? ____ Yes ____ No

Child's Oral Reports: _____

Further Comments: _____

Signature: _____

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